REQUEST TO ADMINISTER MEDICATION AT SCHOOL

I request that designated West Rusk CCISD personnel administer the medication listed below to my child according to the physician/prescribing healthcare provider instructions. I agree to provide any and all medication in compliance with the included medication procedures.

Parent/guardian signature: _____

Student Name: _____ Grade/teacher: _____

PHYSICIAN/PRESCRIBING HEALTHCARE PROVIDER AUTHORIZATION

Name of student: _____ DOB: _____ Grade: _____

Condition for which medication is administered: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: Lunch or other: _____ Med expire date: _____

Side effects to be noted/reported: _____

Other recommendations: _____

Duration (dates) of administration: From _____ To _____ (Limit to one school year)

_____ _____ _____

Physician signature | Print name | Phone/Date

PARENT/GUARDIAN AUTHORIZATION

By signing below, I acknowledge that:

1. I give permission for the designated West Rusk CCISD personnel to administer this medication in accordance with the physician's instructions above.
2. I have read and understand the West Rusk CCISD medication procedures.
3. I give permission for the school to contact the above health care provider about the administration of this medication.
4. I understand that the school district, the Board, and its employees shall be immune from civil liability due to allergic reaction and/or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

_____

Parent/Guardian Name (PRINT)

_____ _____

Parent/Guardian Signature Date